MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Positive Pain Management 2301 Forest Lane, Ste. 310 Garland, TX 75042	MDR Tracking No.: M4-03-9030-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Lumbermens Mutual Casualty Co. c/o Sedgwick P.O. Box 131580 Dallas, TX 75313 BOX 19	Date of Injury: Employer's Name: Qwest Communications International Insurance Carrier's No.: A11350273700010113

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
12/13/02	12/13/02	90900, 90906 & 90889	$230.00	$230.00

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary not submitted.

PART IV: RESPONDENT'S POSITION SUMMARY

Position Summary not submitted; however, the response to the TWCC-60 submitted by insurance carrier representative, Kirk Kuykendall, states, "Carrier accepts pre-authorization acceptance & is scheduling DOS 12/13/02 for $352.00".

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- CPT Codes 90900, 90906, and 90889 for date of service 12/13/02 denied as "V". The healthcare provider received preauthorization (CB226534A) for the disputed date of service. The health care provider was contacted to see if payment had been made. MDR was informed that payment had not been received and that the dispute was still active. Per Rule 133.301(a) the insurance carrier cannot retrospectively deny services for which preauthorization has been obtained. Reimbursement in the amount of $230.00 is recommended.

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $230.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature	Marguerite Foster Typed Name	02/25/05 Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____